CENTE	RS FOR MEDICARE	AND HUMAN SERVICES  & MEDICAID SERVICES	15 <del>4</del>	2/25/17 70th 3/22/170N	INTED: 01/12/2017 FORM APPROVED 1B NO 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	j ' '	TIPLE CONSTRUCTION / () NG 01 • MAIN BUILDING 01	(X3) DATE SURVEY COMPLET D		
		445456	8. WING		01/09/2017		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
SWEETV	VATER NURSING CEN	ľER	976HWY 11SOUTH SWEETWATER, TN 37874				
(X4)ID PREFIX TAG	DEFICIENCY MUST BE	MENT of DEFICIENCIES (EACH PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLANOF CORRECTION (EACH CORRECTIVE ACTIONSHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENT	COMPLETION		
K 000	INITIAL COMMEN	TS	KOC	00			
	Tennessee Departmental health licensure and care facilities on 1/9 survey. Sweetwater found to be in substance and to be in substance and for paid Medicare/Medicaid a Life safety from fire, Protection Association 2012 edition.  NFPA 101 Discharge Discharge from Exit Exit discharge from Exit Exit discharge is arraprovides a level walk provisions of 7.1.7 welevation and shall be obstructions. Addition be a hard packed all accordance with CM Letter 05-38.  18.2.7, 19.2.7, S&C 0. This STANDARD is Based on observation failed to maintain exit affected 2 of 8 smokes. The findings include:  Observation and interevealed the exit discourses station and by accumulations.	at 42 CFR Subpart 483.70(a), and tile related National Fire on (NFPA) standard 101 - a from Exits  stanged in accordance with 7.7, sing surface meeting the respect to changes in emaintained free of hally, the exit discharge shall weather travel surface in S Survey 4114 Certification  5-38  not met as evidenced by: an and interview, the Facility the discharges. This deficiency is compartments.	K 27	Corrective Action for Targeted Are On 1/9/17 the Maintenance Directive had the snow and ice removed at exit discharges located by the Solwing nurses station and room 214.  Identification of Area with Potential be affected  On 1/9/17 the Maintenance Directive checked facility exit discharge areas accumulations of snow and ice afound no other areas affected  Systematic Changes  Measures to assure/meet compliant includes daily monitoring of facility exit discharges for snow and ice when the outside temperature drops to degrees Fahrenheit or below a maintain a supply of melting salt to the in preventing any such build up as it weather requires.	tor the uth  to tor for and ace exit the 32 and use		

Any deficiency \$statement ending with an asterisk () denotes delicency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction und disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567 (02-93) Provious Versions Obsolele

Event ID: 9JUY21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Facility ID: TN6202

TITLE

Batter E.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE. & MEDICAID SERVICES

PRINTED: 01/12/2017 FORM APPROVED OMB NO 0938-0391

	& MEDICAID SERVICES			<u>Ori divid</u>	0938-039	
				(X3) DAT	(X3) DATE SURVEY COMPLETED	
	445456	e. WING		01/	09/2017	
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WATER NURSING CE	VTER		978 HWY 11 SOUTH SWEETWATER, TN 37874			
DEFICIENCY MU	JST BE PRECEDED BY FULL	ID PREFIX TAO	CORRECTIVE ACTION SHOULD BE C	ROSS-	(X5) COMPIEROR DATE	
deficiencies were id acknowledged by th	e administrator during the exit	K27	Results of these audits will be premonthly by the Maintenance Directive Quality Assurance Performance Directive Tecomment Committee for review recommendations until the threshold of 100% compliance is a consecutive months. The Expirector and Maintenance Directive follow up on recommendations for QAPI Committee to assure comparties Quality Assurance Performance Director (Director/Administrative Director/Administrative Director, Director of Nasst. Director, Director of Nasst. Director of Nasst. Director, Director, Services Director, Activities Di Business Office Manager, Mainter	ctor to rmance aw and desired met for ecutive or will om the oliance. rmance onsists strator, ursing, Dietary ervisor, Social rector, luman enance	1 0 1 7	
	PROVIDER OR SUPPLIER WATER NURSING CENTRECTION  SUMMAY STATEM DEFICIENCY MI REGULATORY OR I	TOF DEFICIENCIES OF CORRECTION  (X1) PROVIDERISUPPLIERIGUA IDENTIFICATION NUMBER:  445456  PROVIDER OR SUPPLIER  WATER NURSING CENTER  SUMMAY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	TOF DEFICIENCIES (X1) PROVIDERISUPPLIERIGUA OF CORRECTION  (X2) MULT A, BUILDI  445456  B. WING  PROVIDER OR SUPPLIER  WATER NURSING CENTER  SUMMAY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued  deficiencies were identified and was acknowledged by the administrator during the exit	TOF DEFICIENCIES OF CORRECTION  (X1) PROVIDERISUPPLIERICUA IDENTIFICATION NUMBER:  445456  PROVIDER OR SUPPLIER  WATER NURSING CENTER  SUMMAY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEIDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued  deficiencies were identified and was acknowledged by the administrator during the exit conference on 1/9/17.  Confirmed  WEST OF THE WATER OF THE WA	IT OF DEFICIENCIES OF CORRECTION  (X1) PROVIDERISUPPLIER (X2)  445456  B. WING  STRIET ADDRESS, CITY, STATE, ZIP CODE 978 HWY 11 SOUTH SWEETWATER, TN 37874  SUMMAN STATEMENT OF DEFICIENCIES (EACH) DEFICIENCY MUST BE PRECEIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued deficiencies were identified and was acknowledged by the administrator during the exit conference on 1/9/17.  K271  Monitoring  Results of these audits will be presented monthly by the Maintenance Director to the Quality Assurance Performance Improvement Committee for review and recommendations until the desired threshold of 100% compliance is met for 3 consecutive months. The Executive Director and Maintenance Director will follow up on recommendations from the QAPI Committee to assure compliance. The Quality Assurance Performance Improvement (QAPI) Committee consists of the Executive Director/Administrator, Medical Director, Director of Nursing, Asst. Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Maintenance Director and Rehab Manager and MDS	

FORM CMS-2587 (02-99) Previous Vesions Obsolete

Event ID: 9JUY21

Facility ID: TN6202

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 01/12/2017 FORM APPROVED OMB NO 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				<u>ОМВ ИС</u>	0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	SUPPLIER/CLIA (X2) MUL		MULTIPLE CONSTRUCTION IILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		445456	B. WING			01	/09/2017	
NAME OF	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE ZIP CODE	<u> </u>	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
SWEET	WATER NURSING CEN	ITER			BHWY 11 SOUTH JEETWATER, TN 37874			
(X4) 10 PREFIX TAG	DEFICIENCY MI	IENT OF DEFICIENCIES (EACH IST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAO		PROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THEAPPROPER DEFICIENCY)	CROSS-	(X5) COMPIEnOI DATE	
	NFPA 101 Evacuation	on and Relocation Plan	K7	711	Corrective Action for Targete	d Area		
SS≃D	Evacuation and Ref	ocation Plan			On 1/9/17 and 1/10/1	7 the		
		an for the protection of all			Maintenance Director and			
	patients and for their evacuation in the event of			1	Manger in-serviced kitchen	staff to		
	an emergency.	ndically instructed and kept			familiarize them with the com	ponents	İ	
	Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2				and operation of the kitche	n hood		
					suppression system. On 1/20	/17 the		
					Maintenance Director met with	kitchen		
		of the fire safety plan			staff on the operation and com	ponents	İ	
	components per 18/				of the hood suppression syst	em and		
	18.7.1.1 through 18.	7.1.3, 18.7.2.1.2, 18.7.2.2, rough 19.7.1.3, 19.7.2.1.2,			found staff competent.			
	19.7.2.2, 19.7.2.3				Identification of Area with Pote	ntial to		
	Based on observation	not met as evidenced by: on and interview, the facility			<u>be affected</u>			
		ry staff was trained on the stem and components. This			The hood suppression system is	located		
1		of 8 smoke compartments.			in the kitchen and no other are			
		-			facility is affected. Any dieta	-		
ŀ	The finding includes:				member has the potential	to be		
1   1   -	Observation and inte	rview on 1/9/17 at 10:23 AM			affected by this practice.			
	the hood suppression	ry staff were unfamiliar with system and components.			Systematic Changes			
	NFPA 101, 9.2.3, NF	PA96, 10.5.7			Measures to assure/meet cor	npliance		
	The maintenance di	rector was present when the			includes a monthly audit condu	•		
		ified and was acknowledged			the Maintenance Director of			
		during the exit conference on		1	staff's knowledge of the kitche			
	1/9/17.				suppression system and cor			
					with NFPA 101 and NFPA 96. A			
					kitchen staff will be in-serviced	on hire		
					for correct operation of the	kitchen		
				- 1		1		

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Event ID: 9JUY21

Facility ID: TN6202

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE, & MEDICARD SERVICES

PRINTED: 01/12/2017 FORM APPROVED OMB NO 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			MB NO 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	(X3) DATE SURVEY COMPLETED	
		445456	B. WING		01/09/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, SIAIE ZIP CODE	
SWEET	WATER NURSING CEN	NTER		978 HWY 11 SOUTH SWEETWATER, TN 37874	
(X4) 10 PREFIX TAG	DEFICIENCY M	MENT OF DEFICIENCIES (EACH UST BEPRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAO	PROVIDER'S PLAN OF CORRECTION (I CORRECTIVE ACTION SHOULD BE CRE REFERENCED TO THEAPPROPRIAT DEFICIENCY)	OSS- COMPLETON
K 711	Continued		K 711	Monitoring	ŧ
İ				Results of these audits will be pres	ented
				monthly by the Maintenance Direc	tor to
				the Quality Assurance Perform	nance
				Improvement Committee for review	w and
				recommendations until the de	esired
,				threshold of 100% compliance is m	et for
ľ				3 consecutive months. The Exec	utive
				Director and Maintenance Directo	r will
				follow up on recommendations from	m the
				QAPI Committee to assure compli	ance.
ĺ				The Quality Assurance Perform	nance
				Improvement (QAPI) Comm	ittee
				consists of the Exec	utive
ı				Director/Administrator, Me	edical
		•		Director, Director of Nursing,	Asst.
				Director of Nursing, Dietary Man	ager,
				Housekeeping Supervisor, Me	dical
- 1				Records Coordinator, Social Ser	vices
				Director, Activities Director, Bus	ìness
				Office Manager, Human Reso	urces
		:		Manager, Maintenance Director	and
				Rehab Manager and MDS Coordina	tor. 1/20/17
1				_	
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